

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

In the Matter of)	
)	
Rural Health Care)	WC Docket No. 02-60
Support Mechanism)	
)	

**REPLY COMMENTS OF
Healthcare Anywhere, Inc.**

Respectfully submitted by,

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REPLY COMMENTS

Washington Federal Strategies on behalf of Healthcare Anywhere, Inc., a non-profit entity formed to deliver innovative telemedicine services anywhere they are needed, respectfully submits these Reply Comments in response to the *Further Notice of Proposed Rule Making* ("FNPRM"), released by the Federal Communications Commission ("FCC" or "Commission") on November 17, 2003, in WC Docket No. 02-60. These Reply Comments address some of the Comments filed in this proceeding and reiterate answers to some of the FCC's questions regarding the best means of extending universal service support for mobile rural telemedicine applications, particularly those that require satellite telecommunications to deliver real-time health services.

I. STATEMENT OF INTEREST

Healthcare Anywhere, Inc. is a non-profit entity formed in January 2002. Its mission is to promote telemedicine, including mobile telemedicine, by developing and managing projects that deliver healthcare services to underserved populations. As Healthcare Anywhere expands its reach, it also expects to work with rural health clinics that need new ways to reach out to their communities, to improve post-surgical follow up, to reduce the costs of care, and to facilitate patient care at home, as appropriate. The founders of Healthcare Anywhere created this entity to continue work that they undertook in 2001 to test the use of satellite transmission of mammographic images for real-time reporting.¹ Healthcare Anywhere has designed a program for the operational phases of a mobile digital mammography project that provides breast cancer examinations, with real-time reports, to underserved women in rural settings using telemedicine. Healthcare Anywhere focuses on public health programs providing high quality radiological and diagnostic services in rural areas.

¹ See Gitlin, J., White, D., Fetter, J., Cook, L., and Linton, A., *Mobile Digital Telemammography, Phase I Report, Installation and Testing*, a report submitted to the Susan G. Komen Breast Cancer Foundation, November 2002.

The future of cost-effective, high quality medical care – especially in rural areas - lies in using telemedicine applications to bring doctors, patients, and medical records together. Telemedicine applications have a unique need for high bandwidth because of the urgent need to transmit data intensive medical images with 100% integrity. It is for these reasons that Healthcare Anywhere is participating in this proceeding.

II. DISCUSSION

A. Replies to Other Commenters

1. Is it appropriate to cap support at the level supported for functionally similar terrestrial services?

The Commission sought comment on whether to cap support for satellite-based services at the same amount that would be available to support functionally-similar terrestrial-based services. In its Comments, the American Telemedicine Association argued for such a cap.² While the Commission's question is quite logical, to us the answer is that no such cap is appropriate. The question seems to presume that terrestrial services would be less expensive or more available than satellite services, so the terrestrial services seem to be used as a benchmark. Terrestrial infrastructure may or may not exist, which means that the benchmark may be irrelevant. Thus, a functionally equivalence test for a cap on services may drive analysis that accomplishes nothing.

To the extent that the Commission's, and ATA's, concern is about availability of support for more telemedicine projects, we would note that over 90% of the rural healthcare support funds remain uncommitted each year. If ten mobile clinics each sought support for broadband telecommunications services, which could only be provided by satellite carriers using dedicated satellite links, and if we presume that the support required would cost \$15,000 per month, then the total cost to USAC for the year would still be less than \$2,000,000. The start up cost for

² ATA Comments at 4.

building a fully equipped mobile telemedicine clinic that offers mammography services is nearly \$1,000,000. The development of these mobile clinics takes time and money. While we believe that more clinics will be built over time as the model is proven, we also believe that technology and innovation will keep pace, making more telecommunications services available in more remote locations and reducing the costs of satellite, even as more clinics are created. Our prediction is that costs for connectivity will fall faster than demand increases, thus the financial requests made to the Universal Service Fund would not outpace the available resources.

If the Commission follows the advice of ATA, it will not ensure the availability of funds to “all eligible providers” because placing a cap on support might well stifle the development of mobile telemedicine for years. As a nation, we are attempting to reduce the health disparities between rural and urban America. Mobile telemedicine may be a key part of correcting those healthcare disparities. This is not the traditional approach to healthcare. Yet, if adequate care was being provided in rural areas now, there would be no need for this innovation. We urge the Commission to take this opportunity to write regulations that enable innovation and improvements in healthcare.

We recognize that innovation may have start up costs, including investment in mobile clinics and new healthcare technologies as well as satellite equipment. Even so, by investing now, we will all reap the benefits of improving care and lowering the costs of services sooner. Recent changes in the marketplace bolster the view that new service offerings will develop to match the growing demand. For instance, in 2001 a new, affordable 128 kbps satellite service came into the marketplace. In 2004, we are now hearing about a new 512 kbps satellite service that will be available for a reasonable cost. That makes available four times the bandwidth, in three years at an affordable cost.³ With more demand for services, the pace of innovation is likely to continue, making future services even more affordable than comparable bandwidth today.

³ MCI announced a new service offering shared T-1 capacity on a satellite system available across the continental US for about \$550 per month. This system is not yet robust enough for the current Healthcare Anywhere project, but we hope the system will become more robust so we could use it in the future.

2. Because satellite is not distance sensitive, the maximum allowable distance should be irrelevant to this analysis.

Healthcare Anywhere agrees with most of the views presented by Avera Health in the Comments it filed.⁴ Those Comments posit that “[t]he most equitable basis for comparison in the instance of satellite data services will likely be the comparison of data rates.”⁵ We agree also that it would be appropriate to demonstrate through network maps and quotations from other providers that satellite services are more cost-effective than other services.⁶ The aggregation of the costs of fixed installations will outpace the cost of satellite services at some point, possibly with as few as four sites served. Such a showing is in the public interest. Whatever showing the Commission requires, it should not require so much information that the healthcare provider will need months of research to prove its case. We recommend that the more sites that are part of the mobile healthcare delivery program, the greater presumption that a fixed wire solution is not appropriate. We agree with Avera Health that a healthcare provider will likely incur much higher costs for equipment and network management if it is required to use multiple connections.

We tend to disagree with Avera Health’s analysis of the maximum allowable distance. The maximum allowable distance calculation should not be relevant to any telecommunications connection that is not priced by distance. If distance is irrelevant to the price of the circuit, why would the Commission write a regulation that would limit the choices of a healthcare provider in selecting a telemedicine partner to a particular geographic area? This would impose barriers to the implementation of telemedicine project in ways that are not rationally related to the public interests of promoting better rural healthcare or saving resources. Healthcare Anywhere believes that the Commission should choose a policy that does not measure distances when the pricing of a circuit is not distance-based.

⁴ Comments of Avera Health, filed by Jason Wulf at 3-4.

⁵ Id. at 3.

⁶ Id. at 4.

3. Response to Verizon

In its Comments in this proceeding, Verizon touches upon a number of issues including the possible use of a waiver system to allow support for mobile telemedicine, proof of mobility, and the use of logs to demonstrate that healthcare services were delivered in rural areas. We urge the Commission to take this opportunity to provide some framework to the healthcare community about the way universal service support can be used in a mobile telemedicine environment. The flexibility of a waiver process can be quite appealing. Unfortunately, this approach will significantly increase the transaction costs for a healthcare provider who will have to seek expert advice to work through the waiver process. Further, this will place additional burdens on staff at the rural healthcare division and at the Commission to process the waiver requests. The ensuing processes will slow the completion of healthcare projects and add to their costs.

It is our view that creating a framework for mobile telemedicine providers to make a showing of their rurality, mobility, or isolation from other areas will help to prove that an applicant is a worthy recipient of universal service support. The current regulations already require that the healthcare provider be in one or more of several designated categories, almost all of them non-profit or governmental (except the emergency departments of rural hospitals that have been included because of their public service requirements), to qualify for support. Thus, the current applicant pool is not looking to make a profit on a rural healthcare support reimbursement.

If the Commission were to craft regulations that require: 1. maps; 2. filing of logs of the geographic coordinates where the mobile clinic stops; 3. an explanation of the volume of data that must be moved in a specified time to deliver healthcare effectively; and 4. an estimate of the number of sites the mobile clinic will visit, then we believe that the concerns about waste, fraud and abuse will be addressed. At the same time, these showings will illustrate the need for the services selected in each case. Mobile telemedicine providers will have produced much of this information to plan their projects. Therefore, they should be able to share this information with

the Commission.

We believe that by providing more information, telecommunications service providers will find it easier to bid to provide services. We can envision a circumstance in which a carrier, without existing infrastructure, might see a request from a healthcare provider and use that request for services as the business justification for expanding its network. This could enhance competition, increase broadband services in underserved areas, and provide quality telemedicine in a cost-effective way. Investigating the existing service offerings does not provide any insight into what potential market entrants there might be, but this process help provide better information to the marketplace as it drives expansion of networks. For these reasons, we hope that the Commission will choose to craft regulations that provide certainty to mobile health providers about what they need to show, without those showings being unduly burdensome.

B. Providing Support for Mobile Telemedicine Clinics Use of Satellite Is in the Public Interest.

As Healthcare Anywhere has noted above and throughout its participation in this proceeding, it is working on projects that use technologies in new ways to expand the outreach of quality healthcare. We recognize that it is difficult to write regulations that plan for innovation. Yet, it is what we are urging the Commission to do. The healthcare provider makes its decisions based upon the needs of the patient and community and the best ways to deliver high quality care cost-effectively. Knowing this, the Commission may be able to craft regulations that provide support for eligible rural healthcare providers in ways that are rationally related to the decisions the healthcare providers make in developing telemedicine projects.

Clearly, rural America suffers from lack of access to healthcare, both in emergencies and in access to medical specialists. Telemedicine offers an opportunity to bridge that gap by bringing more resources to rural areas using telecom technologies. Mobile telemedicine offers the ability to cover more distance, maximize the use of expensive medical technologies, and reduce barriers that patients face in access to care. The result is that better healthcare will be

available to those Americans living in rural areas.

Given the disparities between urban and rural care, if it were cost effective to provide better care using traditional models, then why is that not being done? Healthcare Anywhere believes that technology is just now providing the opportunity to solve historical problems in new ways. We are pleased that the Commission has shown such support for this concept through its rulemaking process.

Our experience has shown us that when patients receive immediate feedback from the healthcare community regarding screenings and recommended next steps, those patients are more likely to comply with the recommendations and follow prescribed actions. That is what causes us to believe in real-time transmission of data and reporting back. We know that if a patient gets a mammogram but does not follow through with the next steps, the money spent on the mammogram is wasted. Further, by not acting quickly after breast cancer is detected, the costs are significantly higher – both in terms of dollars spent on treatment and in lives lost. So, Healthcare Anywhere works to develop healthcare delivery plans that will address these concerns – immediacy in reporting, follow up, access to the best care available, and better outreach to the communities where patients live.

In the course of developing these projects, we have discovered that we create new jobs and offer Native Americans and others in rural areas the opportunity to gain experience with new technologies. That helps to strengthen the rural communities and enhance the appeal of living in rural America.

In sum, Healthcare Anywhere seeks support for the use of satellite telecommunications for its current mobile telemedicine project because that approach is the most cost effective. The cost savings persist despite the complexity of re-programming the healthcare imaging equipment to allow for the delays in satellite transmission and engineering the system to function as required. These are not insignificant obstacles. Even so, the costs of designing and building a terrestrial network that could allow the vehicle to reach into truly rural communities, adding additional rural locations as the year progresses, would be far greater. A terrestrial network

might preclude us from taking advantage of the very flexibility that caused this project to be designed to use a mobile health clinic. In planning the project, we learn every month of another remote community that wishes to be added to the route, because they are situated far from mammography services and the local residents need those services. We hope that by being somewhat self-sufficient, bringing our own telecommunications links as part of the mobile clinic, we will be able to serve those who reach out to us in this way.

C. The Commission should create incentives for sharing services, when possible.

Healthcare Anywhere has learned that the creation of one mobile telemedicine clinic will likely lead to the creation of more such clinics.⁷ One potential consequence is that a consortium of such mobile clinics could share burstable satellite telecommunications bandwidth. The Commission might be able to preserve resources and encourage innovation in rural telemedicine by creating incentives for sharing of space segments among mobile telemedicine providers. The telemedicine clinics might purchase more bandwidth, but by sharing the bandwidth, they could purchase more at a lower price than each could purchase separately. The measures of what services are needed relate directly to the amount of data to be moved, the rural areas in which services are provided, and other measurable aspects of telemedicine projects. The Commission's rules regarding support should similarly consider these factors.

III. CONCLUSION

Healthcare Anywhere urges the FCC to modify its rules to allow for uncapped support for the use of satellite services for mobile rural telemedicine applications. The essential elements of analysis should be the amount of data to be moved and the timeliness required to deliver care

⁷ This is the result of other healthcare providers expanding on the efforts of the pioneers. Also, rural communities that benefit from mobile telemedicine tell others about the benefits, and other communities follow the leaders.

effectively. The rural healthcare support mechanism has been underutilized, and growth in the mobile telemedicine field is not likely to outpace innovation and cost reductions for the telecommunications services necessary to support mobile clinics. The Commission could request maps and detailed explanations of healthcare projects to establish a need for the type of bandwidth and connectivity which will be supported, and the information should be tied to the specifics of a project in ways that are clear and measurable. We hope that this approach will lead more carriers to enter the marketplace to support telemedicine applications. Accordingly, Healthcare Anywhere respectfully requests that the Commission adopt the proposals set forth herein.

Respectfully submitted,

/s/

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